



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

HUMPAL PHYSICAL THERAPY PC  
5026 DEEPWOOD CIRCLE  
CORPUS CHRISTI TEXAS 78415

#### **Respondent Name**

TX PUBLIC SCHOOL WC PROJECT

#### **Carrier's Austin Representative**

Box Number 01

#### **MFDR Tracking Number**

M4-12-3094-01

#### **MFDR Date Received**

June 12, 2012

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Outpatient Physical Therapy was provided to Yolanda Mata, per her physician request Walter De Gallo, MD. Authorization was obtained and approved for 8 sessions. All claims for Jan & Feb/2012 were submitted within the 95-day filing deadline with all supporting documentation. Received denials for both Jan & Feb/2012; stating denied for no authorization. Sent in reconsideration for both Jan & Feb/2012; with copies of authorization and all supporting documentation and received denials again stating original decision is being maintained. Dates of service January 11, 23, 26 were paid. Not sure why the remaining dates of service are being denied."

**Amount in Dispute:** \$1,860.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "On January 12 [sic] 2012, Requestor sought preauthorization from Self-Insured's utilization review company, IMO, for 8 sessions (2 times per week for 4 weeks) of Additional Physical Therapy for Employee's left knee. In response, IMO Advisor Tracey R. Adams, M.M. issued a Pre-Authorization determination letter partially preauthorizing medical necessity for 2 sessions of Additional Physical Therapy using CPT codes 97110 and 97140. Despite the partial preauthorization of 2 sessions of Additional Physical Therapy, Requestor nonetheless rendered physical therapy to Employee on 8 additional occasions (1/23/12, 1/26/12, 1/31/12, 2/2/12, 2/7/12, 2/9/12, 2/14/12 and 2/16/12). Upon receipt of Requestor's billing for dates of service 1/23/12, 1/26/12 and 1/31/12, Self-Insured issued payment in accordance with the fee schedule for the two preauthorized sessions of Additional Physical Therapy (1/23/12 and 1/26/12). However, it denied the 1/31/12 session due to the fact that this session was not authorized and/or exceeded the authorized number of PT sessions."

**Response Submitted by:** Creative Risk Funding

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 31, 2012	97110, 97140	\$335.00	\$0.00
February 2, 2012	97110, 97140	\$290.00	\$0.00
February 7, 2012	97110, 97140	\$290.00	\$0.00

February 9, 2012	97110, 97140	\$290.00	\$0.00
February 14, 2012	97110, 97140	\$290.00	\$0.00
February 16, 2013	97110, 97140 and 97002	\$365.00	\$0.00

### ***FINDINGS AND DECISION***

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of health care.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

#### Explanation of benefits

- 197 – Payment denied/reduced for absence of precertification/authorization
- 198 – Payment denied/reduced for precertification/authorization
- 50 – These are non-covered services because this is not deemed a medical necessity by the payer
- 18 – Duplicate claim/service
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment
- W4 – No additional reimbursement allowed after review of appeal/reconsideration

#### **Issues**

1. Did the requestor obtain preauthorization for CPT codes 97110 and 97140 rendered on January 31, 2012 to February 16, 2012?
2. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.305 and §133.307 and is disputed CPT code 97002 eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?
3. Is the requestor entitled to reimbursement?

#### **Findings**

1. Per 28 Texas Administrative Code §134.600 "(p) Non-emergency health care requiring preauthorization includes: (5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (A) Level I code range for Physical Medicine and Rehabilitation, but limited to: (i) Modalities, both supervised and constant attendance; (ii) Therapeutic procedures, excluding work hardening and work conditioning; (iii) Orthotics/Prosthetics Management; (iv) Other procedures, limited to the unlisted physical medicine and rehabilitation procedure code..."

Review of the preauthorization determination letter dated August 18, 2012 issued by IMO documents a partial authorization for CPT codes 97110 and 97140. The preauthorization letter states in part "Determination: partial preauthorization of 2 post injection PT visits for 97110 and 97140 in accordance with ODG and clinical presentation to update HEP."

The insurance carrier submitted documentation in the form of an EOB documenting that payment was issued for the 2 pt preauthorized PT visits (CPT codes 97110 and 97140) rendered on January 23, 2012 and January 26, 2012. As a result the disputed CPT codes 97110 and 97140 rendered on January 31, 2012, February 2, 2012, February 7, 2012, February 9, 2012, February 14, 2012 and February 16, 2012 exceeded the 2 preauthorized PT sessions and therefore, payment cannot be recommended for CPT codes 97110 and 97110 rendered on January 31, 2012, February 2, 2012, February 7, 2012, February 9, 2012, February 14, 2012, and February 16, 2012.

2. 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury.

28 Texas Administrative Code §133.305(b) requires that “If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021.”

28 Texas Administrative Code §133.307(e)(3)(G) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General). The appropriate dispute process for unresolved issues of medical necessity requires the filing of a request for review by an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. Review of the submitted documentation for CPT code 97002 finds that there are unresolved issues of medical necessity for the same service(s) for which there is a medical fee dispute.

No documentation was submitted to support that the issue of medical necessity has been resolved for CPT code 97002 rendered on February 16, 2012 prior to the filing of the request for medical fee dispute resolution.

As a result, the requestor has failed to support that CPT code 97002 is eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

3. Reimbursement is therefore not recommended for CPT codes 97110 and 97140 rendered on January 31, 2012, February 2, 2012, February 7, 2012, February 9, 2012, February 14, 2012 and February 16, 2012 and for CPT code 97002 rendered on February 16, 2012.

### **Conclusion**

For the reasons stated above, the requestor has failed to establish that the respondent’s denial of payment reasons concerning medical necessity have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 413 prior to the submission of a medical fee dispute request for the same services. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute for CPT code 97002. As a result, no amount is ordered.

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due for CPT codes 97110 and 97140. As a result, the amount ordered is \$0.00.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

### **Authorized Signature**

_____	_____	September 26, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**